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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who was injured on X. The biomechanics of the injury was not available in the medical records. X was diagnosed with X. X was seen by X, DO on X. X underwent X at the X by Dr. X. The X and X and X. On X visited Dr. X. X continued to X. X was able to X. X got X. X wanted to X. Each X and X. The criteria had X. X got more X. X had X. X had X. On X was seen by Dr. X. X felt the X. X with a X. X had a X. X did X and X. X had a X. X responded X. Dr. X that the peer doctor should be more concerned about X and X use of X. The ODG specifically stated that X. The medical board supported intervention in X. X had X. The treatment to date included X. Per a peer review by X, MD, dated X, the request for X at the X was noncertified. Rationale, "There is X. The claimant just had a X on X with no follow up exam to indicate result or current findings. Also, there is no indication the X provided at X as that time has not passed yet. X is not typically supported with this, and X, so there is X. Therefore, X with X is not medically necessary." Per a peer review by X MD, and the utilization review dated X, the request for X was noncertified. Rationale, "Per X regarding criteria for X. X must be corroborated by

imaging studies and when appropriate, X. A request for the procedure in a X. X should X." In this case, there is no documented evidence of X. X revealed X. X is not shown to be medically necessary."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a peer review by X, MD, dated X, the request for X was noncertified. Rationale, "There is X MRI to review to support this. The claimant just had a X with no follow up exam to X. Also, there is no indication the X. X is X this. Therefore, X is not medically necessary." Per a peer review by X MD, and the utilization review dated X, the request for X was noncertified. Rationale, "Per ODG X regarding criteria for X must be well documented, along with X. X must be X. A request for the procedure in a patient with X additional documentation of X. X should require documentation that previous X." In this case, there is no documented evidence of X. X on X revealed no evidence of X. X is not shown to be medically necessary."

There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Although the patient subjectively reported X. There are X submitted for review.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines, so the denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL